STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005053	A. BUILDING: _____ B. WING _____	10/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of 2 State hospital complaints. Complaint Number: IN 00124968 Unsubstantiated: lack of sufficient evidence. Complaint Number: IN00125929 Unsubstantiated: lack of sufficient evidence. Date: 10-15-13 and 10-16-13 Facility Number: 005053 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor Memorial Hospital of South Bend is in compliance with 410 IAC 15-1.5-6, Nursing service and 410 IAC 15-1.5-2, Infection control, Indiana Hospital Licensure Rules. QA: claughlin 10/18/13	S 000		